

HEALTH PLAN WEEK

Timely Business, Financial and Regulatory News of the Health Insurance Industry

Contents

- 3** *Financial News*
- 4** Proposed Calif. Medicaid Cut May Lower Health Plan Earnings
- 4** CMS Proposes New Rules for Promotion of Medicare Products
- 6** *Table: 2007 Executive Stock Options at Publicly Traded Managed Care Firms*
- 7** *Table: 2007 Executive Compensation at Publicly Traded Managed Care Firms*
- 8** *Health Plan Briefs*

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Health Plan Execs See Smaller Bonuses as Companies Push Performance-Based Pay

While it's unlikely that health plan CEOs were forced to clip coupons and car pool to save money, top executives from several publicly traded firms saw substantially smaller cash incentives in 2007, according to *HPW's* annual analysis of executive compensation figures in company proxy statements (see table, p. 7). One exception, though, was CIGNA Corp. Chairman and CEO H. Edward Hanway, the top-paid health plan executive in 2007, who saw his bonus rise by \$6.7 million.

The latest filings with the Securities and Exchange Commission (SEC) also show that health plans continue to place greater emphasis on performance-based awards such as restricted stock grants and time-vested cash grants. Base salaries for most health plan executives increased just modestly in 2007.

"Bonuses are definitely being tied more to production," says Brian Kelley, a partner with the The Buffkin Group, LLC, a national executive search and consulting firm. "Compensation committees are under tremendous scrutiny because this is a low-margin business, but the expectations in the public sector are high and [the committees] want these CEOs to get paid based on their performance."

Rather than boosting salaries, compensation committees are shifting to more of a pay-for-performance strategy for their top executives, adds Myrna Hellerman, senior vice president with Sibson Consulting, the human resources consulting division of Segal Co. "The committees are looking at the overall [financial] opportunity provided each year. And that's where they're measuring their competitiveness," she explains. And in response to criticism from investors and the general public, many publicly traded firms in general have de-emphasized the base salaries paid to their top executives, she adds.

continued on p. 5

With Patient Debt Soaring, Insurers Help Arm Providers With New Collection Tools

High deductibles aren't just for consumer-directed health plans anymore. Employers and their employees are increasingly turning to plans that include substantially raised copayments, higher deductibles and coinsurance to help stabilize soaring premium costs. However, a growing number of enrollees are finding it difficult to pay their share of the bill when they receive services. Health plans interviewed by *HPW* say the problem is still relatively small, but they expect it to increase as more consumers opt for low-premium, high-cost-sharing policies.

Caught on the other end of the problem are physicians and hospitals, who increasingly find themselves saddled with debts incurred by their patients. Many providers say they didn't know the extent of the patient's financial obligation when they delivered their services.

In 2007, First Consulting Group released a report that analyzed the impact high deductibles have on physicians. According to the study, the amount of billed charges

transferred to patients over the past year had risen 19%, greatly increasing the burden put on physicians to manage patient collections. Adding to the challenge is the fact that consumers tend to rate paying their health care bills among their lowest priorities. The report notes that while physician practices must begin re-engineering their revenue cycles, they also need help from health insurers.

Health plans are taking several steps to work with their network providers to help them address the issue. Among the tools being used and/or tested: patient financial share responsibility calculators, real-time claims adjudication, special credit or debit cards, and a process through which the health plan directly pays the patient's share of the bill to the provider.

Taking a page from the financial services industry, Humana Inc. early this year introduced its HumanaAdvance card (a guaranteed-issue credit card) through Republic Bank. The card offers a line of credit that members can use at specific health care points of service. "In other sectors of the economy, customers swipe a credit or debit card or write a check when they make a purchase," Beth

Bierbower, Humana's vice president of product innovation, tells *HPW*. "We want to start working more like these other sectors." The card can be used by members enrolled in any type of plan that includes a high deductible, including consumer-directed plans.

The HumanaAdvance card is activated only when members use it, and users pay back what they owe through payroll deductions. Humana charges an up-front fee for the card but no interest rate for the first six months, so users can avoid incurring additional charges. Bierbower says that employers often pay the up-front fee or split the fee with employees. A member's credit limit varies according to his or her salary.

Humana is pilot testing the card with a 400-employee company that it didn't identify, and will introduce the card to its own employees in July. A handful of other clients will start using the card in the second half of 2008.

Tool Helps Estimate Patient's Share

Blue Cross Blue Shield of Florida also has been watching the growth in the number of its members opting for low-premium, high-deductible plans. "Because high-deductible health plans of all types are becoming popular, we feel it is our obligation to make it as easy as possible for providers to deal with this," Barney Dreistadt, the Florida Blues plan's director of provider service development, tells *HPW*. "Regardless of what happens at the national level, it is likely that the member's financial share of the bill will continue to increase."

The Blues plan integrated its CareCalc tool into a real-time claims adjudication feature available through Availity, an electronic data interchange clearinghouse offering providers a single point of entry to a network of health plans. The Florida Blues plan, Humana and Health Care Service Corp. (HCSC) are founding partners of Availity.

The CareCalc tool allows providers to calculate the patient's financial share at any point in the patient contact cycle, including when the patient makes an appointment. Using the Availity portal, provider staff enters the patient's eligibility information and the medical codes for the services to be provided. In less than two minutes, both the patient and the provider have a printout of the patient's estimated financial obligation.

HCSC, which operates Blue Cross and Blue Shield plans in Illinois, Texas, New Mexico and Oklahoma, has the ability — through its banking partner — to pay its network providers directly for the expenses patients owe through their health savings accounts (HSAs).

Kirk Pion, HCSC's executive director for product management, tells *HPW* that the company in 2005 developed an integrated system through which HSA enrollees can elect to have their funds accessed during the claims-

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adjudication process and paid directly to the provider. "When we get a claim, we automatically reach out to the HSA and pay the provider directly for the service," Pion says, adding that "we're basically functioning as an ATM machine." About 60% of HCSC's employer clients elect to pick up a share of the employee's deductible by contributing to his or her HSA, he says.

Pion tells *HPW* that while consumer-directed products with high deductibles and, often, high copays now constitute only 6% of the company's product portfolio, this is a definite growth area for the company. Pion says that participation rates average 40% to 45%.

Other approaches to reducing patient and provider exposure to debt because of high-deductible and high-

copay options have met with mixed results. United-Health Group's OnePay program, through which it directly paid providers the amount a patient owed, was relatively short-lived. For physicians agreeing to a discounted rate, United either deducted the member's share from a health account or charged the member's credit line. But after one year, the pilot failed to achieve critical mass toward a larger rollout. A United spokesperson tells *HPW* that based on its experiences with OnePay, the company is exploring other credit programs for members. United also offers its network physicians real-time claims adjudication through its dedicated physician Web site.

Empire Blue Cross Blue Shield, meanwhile, no longer offers its HealthPay credit card, launched as a pilot in

FINANCIAL NEWS

◆ **Triple-S Management Corp. on May 6 reported first-quarter 2008 net income of \$1.2 million, or 4 cents per share, compared with \$4.5 million, or 17 cents per share, for same period a year ago.**

The Puerto Rico-based insurer said its profits were affected by an after-tax loss of \$7.1 million, or 21 cents per share, due in part to unrealized losses on investments and derivatives. Operating revenues for the quarter increased 16.1% to \$421.5 million from \$363.1 million in the year-ago period, Triple-S said. Medical premiums totaled \$359.9 million, up 17.8% from the same period last year, it added. This increase was primarily due to higher Medicare Advantage (MA) member enrollment and rate hikes across all businesses, Triple-S said. The company said its outlook for full-year 2008 remains unchanged, with total medical enrollment expected to grow roughly 1% and MA enrollment rising 30% to 35%. Contact Kathy Waller at investorrelations@ssspr.com.

◆ **Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals and their subsidiaries (KFHP/H) on May 6 posted 2008 first quarter net income of \$250 million, compared with \$698 million in the first quarter of 2007.** The decline in net income was due to the recent turbulence in the financial markets, which affected KFHP/H's investment portfolio, the company said. This resulted in a \$295 million decrease in non-operating income in the 2008 quarter, compared with a \$177 million gain in last year's period, it added. Total operating revenue in the 2008 quarter was \$10.1 billion, compared with \$9.4 billion in the year-ago period, KFHP/H said. Operating income increased to \$545 million from

\$521 million, it said. In addition, KFHP/H noted, more than 25,000 new members joined Kaiser Permanente in the first three months of the year. Total membership is nearly 8.7 million, it added. Contact Sybil Wartenberg at sybil.k.wartenberg@kp.org.

◆ **Assurant, Inc. on May 1 said that first-quarter 2008 net income increased 4% to \$186.8 million, or \$1.57 per diluted share, from \$179.5 million, or \$1.45 per diluted share, in the same period last year.**

The 2008 period profit included \$28.2 million of after-tax realized losses from other-than-temporary impairments in the investment portfolio, said Assurant, which provides specialized insurance and insurance-related products and services. The company also reported net earned premiums of \$1.94 billion, up 10% from the same period last year. This increase was driven primarily by growth in Assurant Specialty Property and Assurant Solutions, the insurer said. Contact Drew Guthrie at drew.guthrie@assurant.com.

◆ **eHealth, Inc., an online source of health insurance for individuals, families and small businesses, on May 1 posted first-quarter 2008 net income of \$3.3 million, or 13 cents per share, compared with net income of \$2.3 million, or 9 cents per share, in the year-ago period.** Submitted applications for individual and family products increased 25% to 114,500 from 91,800 applications in the first quarter of 2007, eHealth said. Estimated membership on March 31, 2008, was 558,200, a 26% increase from 443,200 on the same date a year ago, it added. Contact Kate Sidorovich at (650) 210-3111.

2005 with American Express. The card featured direct access to a member's HSA account or to a line of credit. An Empire spokesperson tells *HPW* that the pilot test was halted when American Express decided to exit the health care payment business.

Contact Jim Turner for Bierbower at jturner@humana.com, Mark Wright for Dreistadt at mark.wright@bcbsfl.com, Ross Blackstone for Pion at ross_blackstone@bcbstx.com, Lisa Greiner for Empire Blue Cross Blue Shield at lisa.greiner@empireblue.com, and Daryl Richard for United at daryl_p_richard@uhc.com. Contact First Consulting Group at (800) 345-0957 or visit www.fcg.com. ♦

Proposed Calif. Medicaid Cut May Lower Health Plan Earnings

California health plans servicing the state's Medicaid programs — Medi-Cal and Denti-Cal — could face reimbursement cuts under the state's proposed budget cuts. Already, California's provider groups, including the California Hospital Association (CHA) and the California Medical Association (CMA), filed a lawsuit against the California Department of Health Care Services (CDHCS), which is responsible for the programs. The suit alleges that the budget cuts would imperil providers' ability to service beneficiaries of the program. And at least one health plan has said the cuts would affect earnings for full-year 2008.

The proposed reduction is 10%, in the overall Medicaid budget Norman Williams, spokesperson for CDHCS, tells *HPW*. While he says the department cannot discuss the lawsuit, he notes that "no health plans were party to the suit filed [May 5, 2008]."

"The class-action lawsuit seeks an immediate injunction to block the reduction in Medi-Cal payments," said CHA. "In February, the legislature approved and the governor signed into law a total of \$1.3 billion in cuts to the Medi-Cal program in an effort to stem the state's budget crisis," according to a CHA release. The hospital advocacy organization said the reductions are scheduled to take effect July 1 unless the court intervenes. It added that Medi-Cal payments to hospitals, pharmacists and adult day health care providers are slated to be delayed in June and August.

And CMA President Richard Frankenstein, M.D., asserted that "Medi-Cal already doesn't cover the cost of providing care.... This chronic underfunding is forcing many doctors to leave the Medi-Cal program."

"We've publicly stated that [the proposed cuts would] cause our reimbursement to be reduced somewhere in the mid- to higher-single digits," says Health Net, Inc. spokesperson David Olson. Health Net's full-

year 2008 earnings will be hurt if the proposed cuts are enacted, he says. Olson adds that the plan had 720,000 Medi-Cal beneficiaries as of March 31.

Despite the lower proposed reimbursements, he says the plan has not decided to sue the state. "We continue to monitor the situation in [regard to] the final budget from the state." He also says he is not sure whether Health Net has seen the lawsuit, nor would he comment "as to whether or not we would do anything about it."

Williams says, "We understand these are painful and difficult reductions, but in light of the extreme fiscal crisis facing California, Medi-Cal cannot be — as the state's second largest general fund expenditure — exempted from the solution."

Other health plans operating in California and participating in Medi-Cal did not respond to requests for comment.

For more information, call Williams at (916) 440-7660, Olson at (818) 676-6978 or CHA spokesperson Jan Emerson at (916) 552-7516. ♦

CMS Proposes New Rules for Promotion of Medicare Products

Health plans that sell Medicare Advantage (MA) plans and stand-alone Prescription Drug Plans (PDPs) would have to modify the way they market the products to potential enrollees under new rules proposed by CMS on May 8. The proposed changes, which the agency says are designed to protect Medicare beneficiaries, would require health plans to modify the commissions they pay to sales staff and eliminate some tactics such as cold-calling and door-to-door solicitation. In addition, CMS proposed changes to ensure that that 90% of new enrollees in MA Special Needs Plans (SNPs) be special-needs individuals.

Competition for new members has prompted some health plans to dramatically boost the commission rates they pay brokers who market MA plans. During last fall's open-enrollment season, agents and brokers in some parts of the country earned commissions as high as \$800 for each person they enroll in an MA plan (*HPW* 12/19/07, p. 1).

To discourage "churning" of beneficiaries from plan to plan during enrollment — based on the highest commissions — a health plan would be required to offer the same commission for all of its MA products sold by its brokers, CMS spokesperson Peter Ashkenaz tells *HPW*. Likewise, all of its PDP commissions must be the same. "However, the commissions for PDP do not have to be the same as MA and MA-PD [i.e., MA prescription drug]," he explains. CMS is not setting the commission amounts.

CMS has proposed a \$15 “value limit” on promotional items plans offer to potential enrollees. Pre-arranged appointments to market products would be limited to the scope agreed to by the beneficiary in advance, CMS said. And MA plans using independent agents would be required to use agents licensed by the state. The agency would have the authority to levy a penalty of up to \$25,000 for each violation of the rule. It also would streamline eligibility determinations for Medicare’s low-income subsidy (LIS) and limit beneficiary liability.

For SNPs covering beneficiaries eligible for Medicare and Medicaid, the rule would set standards to ensure their access to “essential services” available through Medicaid in addition to Medicare benefits.

To see a copy of the proposal, visit www.cms.hhs.gov/HealthPlansGenInfo/Downloads/PDP-MA_Proposed_Rule.pdf. The agency will accept public comments on the proposal until 5 p.m. Eastern Time July 15.

Call the CMS Office of Public Affairs at (202) 690-6145. ✧

AIS is sponsoring an audioconference June 5 about the new MA and Part D marketing rules. Registration will begin soon at www.AISHealth.com.

Hemsley’s Total Compensation Drops

continued from p. 1

UnitedHealth Group President and CEO Stephen Hemsley saw his annual base pay increase to \$1.3 million in 2007 from about \$1 million the previous year. However, his stock-option awards dropped from \$11.3 million in 2006 to \$8.1 million in 2007. His total compensation, according to the company’s filings, fell from \$15.5 million in 2006 to \$13.2 million last year.

In 2005, former United CEO William McGuire, M.D., was the nation’s highest-paid health plan executive with total compensation in excess of \$124 million. He was the nation’s third-highest-paid CEO, according to *Forbes Magazine’s* annual ranking of chief executive compensation. McGuire resigned in October 2006 in the wake of a stock-option backdating scandal that later prompted a formal SEC investigation (*HPW 12/11/06, p. 1*).

In 2007, Hemsley’s pay consisted entirely of base salary and annual and long-term cash incentives, according to the company’s filing. United’s compensation committee awarded Hemsley a 2007 annual cash incentive award of \$2.5 million. His long-term cash incentive was \$1.1 million, according to proxy statements. Hemsley became CEO shortly after McGuire’s departure. Overall, Hemsley took home about \$5 million in 2007, down from more than \$7 million a year earlier. He ranked 346th on *Forbes’* list, just above WellPoint, Inc. CEO Angela Braly.

In its filings, United said Hemsley’s total compensation “was well below the median of CEOs at peer group companies.” United did not increase his base salary for 2008.

While Hemsley did not receive a stock-option award in 2007, Chief Financial Officer George Mikan received 250,000 stock options (see table, p. 6). The options, however, won’t hold any value until the company’s stock price climbs above \$54.41. United’s stock closed at \$33.00 on May 8.

Last fall, United revised the list of “peer group” companies that it uses to evaluate executive compensation. The group now consists of 22 similarly sized companies and five large managed care firms. New peer group companies include McDonald’s Corp., Boeing Co., Dow Chemical Co. and United Parcel Service, Inc. Health plans in the group include CIGNA, WellPoint and Humana Inc.

CIGNA CEO Is Top-Paid Plan Exec

CIGNA’s Hanway saw his stock awards fall from nearly \$2 million in 2006 to \$453,000 last year, according to the company’s filing. (CIGNA has substantial non-health as well as health product operations). Hanway also saw his option awards decrease from about \$6.0 million to \$4.6 million. However, his bonus, which includes non-equity incentive plan compensation, skyrocketed from \$11.2 million in 2006 to nearly \$18 million. According to CIGNA’s proxy statement, Hanway’s total 2007 compensation was \$25.8 million — up from \$21.0 million a year earlier.

Among publicly traded health plans, Hanway was the top-paid CEO in 2007, and is the nation’s 53rd high-

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est paid executive at publicly traded firms, according to *Forbes*.

In its filings, Aetna Inc. said 2007 was a “very successful year for the company and its shareholders.” The insurer says its executive compensation philosophy has directly contributed to its financial performance. In 2007, Aetna said organic net membership grew by 730,000 members (4.7%) from the end of the previous year. Total membership at the end of 2007 was 16.9 million — up 9.2% from the end of 2006. “Over the past five years, our total shareholder return has exceeded both the Standard & Poor’s 500 and the average of the returns of our health care competitors,” the company said in its proxy statement.

Aetna Chairman and CEO Ron Williams received cash incentives of \$1.9 million in 2007, down substantially from the \$7.7 million he received in 2006. However,

he received \$12.8 million in stock-option awards in 2007, which was more than double what he received in 2006. Overall, Williams’ total compensation in 2007 was \$23.0 million — up from the \$19.8 million reported for a year earlier. His base salary of \$1.1 million in 2007 was up about \$23,000 from the previous year.

In 2007, Health Net President and CEO Jay Gellert took home \$1.18 million in base salary (up from \$1.06 million the previous year). However, his stock option awards fell from \$1.4 million to \$949,000. And while he received \$1.2 million in cash incentives in 2006, the company’s filing shows that he did not receive any such bonus in 2007. Gellert’s total compensation of \$3.7 million in 2007 was 37% lower than it was the previous year, according to the company’s proxy statement.

Coventry Health Care, Inc., CEO Dale Wolf saw his base salary increase about 9% to \$925,000. He can earn

2007 Executive Stock Options at Publicly Traded Managed Care Firms*

Name/Title	Company	Number of Stock Options Granted in 2007	Exercise Price per Share	Closing Stock Price on May 8
Stephen Hemsley, President/CEO	UnitedHealth Group	0	\$54.41	\$33.00
George Mikan III, Executive Vice President (EVP), Chief Financial Officer (CFO)		250,000	\$54.41	
Angela Braly, President/CEO (as of June 2007)	WellPoint, Inc.	413,333	\$80.81	\$52.51
Wayne S. DeVeydt, CFO, EVP		75,200	\$81.07	
H. Edward Hanway, Chairman/CEO	CIGNA Corp.	223,125	\$46.90	\$41.17
Michael Bell, EVP/CFO		77,283	\$46.90	
Ronald Williams, Chairman/ CEO	Aetna Inc.	706,124	\$42.57	\$43.53
Mark Bertolini, President (as of May 2007)		456,780	\$42.57	
Jay Gellert, President/CEO	Health Net, Inc.	0	\$54.50	\$28.10
James Woys, EVP/Chief Operating Officer (COO)		32,500	\$54.50	
Michael McCallister, President/CEO	Humana Inc.	129,758	\$62.10	\$40.08
James Murray, COO		67,042	\$62.10	
Dale Wolf, CEO	Coventry Health Care, Inc.	225,000	\$60.01	\$44.98
Thomas McDonough, President		125,000	\$60.01	
Robert Pollock, President/CEO	Assurant, Inc.	132,350	\$53.48	\$65.54
Michael J. Peninger, EVP/ Interim CFO		32,450	\$53.48	
J. Mario Molina, M.D., President/CEO	Molina Healthcare, Inc.	36,000	\$31.32	\$24.89
John Molina, CFO		36,000	\$31.32	
James Carlson, President/ CEO	AMERIGROUP Corp.	63,220	\$32.74	\$25.25
Jeffrey McWaters, Chairman/ former CEO		162,816	\$32.74	
Ramón M. Ruiz-Comas, President/CEO	Triple-S Management Corp.	465,517	\$14.50	\$17.80
Socorro Rivas-Rodríguez, President, Triple-S, Inc.		155,172	\$14.50	

Editor’s note: WellCare Health Plans, Inc. was omitted from this table because it has delayed reporting full financial and operating data for 2007 in light of an ongoing investigation by federal and state agencies. HealthSpring, Inc. and Centene Corp. were omitted because the companies did not grant options to their top two highest-paid executives in 2007.

*The table includes both the top-ranked executive and the second-highest-paid health plan executive for each company on the basis of salary. SOURCE AND METHODOLOGY: Compiled by Atlantic Information Services, Inc. from company proxy statements.

up to 150% of his base salary by reaching certain targets that “build the value of the company and generate competitive total returns to stockholders,” according to the company’s filing. He received \$7.8 million in stock-option awards in 2007, up from the \$7.1 million he

received the previous year. His bonus and other compensation in 2007 were up slightly from 2006.

For more information, contact Kelley at brian@thebuffkingroup.com and Hellerman at mhellerman@sibson.com. ✧

2007 Executive Compensation at Publicly Traded Managed Care Firms*

Name/Title	Company	Annual Salary	Stock Awards ¹	Option Awards ¹	Bonus ²	Other Annual Compensation
Stephen Hemsley, President/CEO	UnitedHealth Group	\$1,300,000	\$0	\$8,134,691	\$0	\$94,838
George L. Mikan III, Executive Vice President (EVP), Chief Financial Officer (CFO)		\$650,000	\$0	\$3,224,258	\$0	\$71,874
Angela Braly, President/CEO	WellPoint, Inc.	\$922,269	\$2,160,159	\$5,240,149	\$588,311	\$179,677
Wayne S. DeVeydt, CFO/EVP		\$515,862	\$1,083,855	\$1,412,971	\$215,424	\$80,240
H. Edward Hanway, Chairman/CEO	CIGNA Corp.	\$1,110,000	\$452,886	\$4,626,316	\$17,999,970	\$32,021
Michael Bell, EVP/CFO		\$600,577	\$12,974	\$1,209,445	\$4,950,000	\$1,327
Ronald Williams, Chairman/CEO	Aetna Inc.	\$1,095,785	\$5,309,197	\$12,887,276	\$1,900,000	\$104,162
Mark Bertolini, President (as of May 2007)		\$711,847	\$705,020	\$2,764,762	\$889,884	\$26,317
Jay Gellert, President/CEO	Health Net, Inc.	\$1,180,769	\$1,425,243	\$949,406	\$0	\$130,812
James Woys, EVP/Chief Operating Officer (COO)		\$622,132	\$1,164,683	\$568,495	\$0	\$118,258
Michael Neidorff, Chairman/CEO	Centene Corp.	\$1,000,000	\$3,977,009	\$2,296,518	\$0	\$477,224
William Scheffel, EVP, Specialty Business Unit		\$510,000	\$350,000	\$107,571	\$0	\$26,362
Michael McCallister, President/CEO	Humana Inc.	\$973,558	\$0	\$2,438,685	\$1,950,000	\$511,321
James Murray, COO		\$629,423	\$0	\$1,262,294	\$945,000	\$220,254
Dale Wolf, CEO	Coventry Health Care, Inc.	\$925,000	\$1,688,743	\$7,846,664	\$3,821,226	\$588,190
Thomas McDonough, President		\$885,000	\$1,718,203	\$3,289,535	\$1,255,907	\$232,518
Robert Pollock, President/CEO	Assurant, Inc.	\$850,000	\$344,320	\$1,221,758	\$791,917	\$158,654
Michael J. Peninger, EVP/ Interim CFO		\$470,000	\$102,216	\$377,140	\$658,000	\$150,470
J. Mario Molina, M.D., President/CEO	Molina Healthcare, Inc.	\$775,000	\$0	\$594,079	\$117,082	\$10,728
John Molina, CFO		\$700,000	\$0	\$594,079	\$28,473	\$26,113
James Carlson, President/CEO	AMERIGROUP Corp.	\$608,086	\$81,042	\$349,652	\$1,976,250	\$7,053
Jeffrey McWaters, Chairman/former CEO		\$621,710	\$853,013	\$3,835,139	\$2,664,857	\$12,658
Herbert Fritch, President/CEO	HealthSpring, Inc.	\$737,500	\$0	\$221,783	\$0	\$7,875
Gerald Coil, EVP/COO		\$392,564	\$0	\$168,652	\$0	\$49,113
Ramón M. Ruiz-Comas, President/CEO	Triple-S Management Corp.	\$541,500	\$51,370	\$51,301	\$431,000	\$91,924
Socorro Rivas-Rodríguez, President, Triple-S, Inc.		\$395,700	\$17,123	\$17,100	\$325,400	\$65,908

Editor’s note: WellCare Health Plans, Inc. was omitted from this table because it has delayed reporting full financial and operating data for 2007 in light of an ongoing investigation by federal and state agencies.

*The table includes both the top-ranked executive and the second-highest-paid health plan executive for each company, on the basis of salary.

¹Reflects the company’s estimated fair value related to options and awards granted in 2007 and prior years.

²Includes non-equity incentive plan compensation.

SOURCE AND METHODOLOGY: Compiled by Atlantic Information Services, Inc. from company proxy statements.

HEALTH PLAN BRIEFS

◆ **WellPoint, Inc. said April 29 that it intends to acquire DeCare Dental, an administrator of dental benefit plans.** DeCare, a Minneapolis-based company that markets plans nationally as Securian Dental, manages 4 million members representing 21,000 group customers, the health plan said. According to WellPoint, the purchase will allow WellPoint to improve its ability to offer dental products, drawing upon DeCare's expertise in dental analytics and operations. WellPoint said that DeCare now serves 10 dental plans primarily as a third-party administrator. The dental firm also operates DeCare Systems Ireland (DSI), which offers dental benefits in Ireland as Vhi DeCare Dental, and enterprise software services, e-business applications and application performance tuning. Upon the completion of the acquisition, WellPoint's dental services will provide and administer dental benefits to 9 million members and have one of the nation's largest dental PPO networks. Call WellPoint spokesperson Cheryl Leamon at (317) 488-6748.

◆ **Florida's legislature passed S.B. 2534, dubbed Cover Florida, which would provide lower-cost health plan options to Florida's 3.8 million uninsured individuals.** Gov. Charlie Crist (R) intends to sign the bill when he receives it from the legislature, according to a spokesperson for his office. Cover Florida will allow the state to negotiate with health plans to develop affordable health coverage for uninsured Floridians ages 19 to 64. Businesses with fewer than 50 employees would be aided in negotiating health insurance rates by an organization funded by \$1.5 million in state funds. Uninsured Florida residents could purchase limited plans for as little as \$150 per month. Plans would be exempt from state mandates that require coverage for a range of items and procedures, according to the *South Florida Sun-Sentinel*. The policies would cover preventive care and office visits but not care from specialists or long-term hospitalizations. Call Crist's public affairs office at (850) 488-5394.

◆ **Blue Cross and Blue Shield of Minnesota intends to launch its own disease management programs once its contract with Nashville, Tenn.-based Healthways, Inc. expires in January,** *The Minneapolis/St. Paul Business Journal* reports. Healthways has run the Minnesota Blues plan's disease management programs since 2002. The insurer intends to hire 90 nurses for its new in-house service, and will test the product this fall before it is made

available to members, the newspaper reports. The insurer is expected to launch an advertising campaign this month to promote the new program to employers. Visit www.bluecrossmn.com.

◆ **Blue Cross Blue Shield of Arizona launched a multicultural marketing campaign targeting Arizona Hispanics.** According to the health plan, the campaign uses a variety of tools to target Hispanics, among them television, radio and print advertisements and also "webisodes" — videos broadcast via the Web — designed to appeal to younger audiences. About 1.8 million or 30% of Arizona's population is Hispanic, the Arizona Blues plan said. The health plan stated that its market research showed "approximately half a million — or 25% — of Arizona's Hispanics lack health insurance." Call Arizona Blues spokesperson Regena Frieden at (602) 864-4046.

◆ **Rodney Moyer, former executive vice president of The Oath for Louisiana, pleaded guilty to conspiring to give insurance regulators financial reports that falsely said the health-plan company had enough reserves to pay the medical bills of its 80,000 subscribers.** Moyer admitted guilt under an agreement with prosecutors that could require him to testify against other The Oath executives named in an April indictment, according to *The Times-Picayune*. The trial began May 1 before Louisiana U.S. District Judge Eldon Fallon. The Louisiana Department of Insurance did not respond to a request for comment by *HPW's* press time. Call insurance commissioner spokesperson Amy David at (225) 342-5423.

◆ **CMS said it began piloting, on April 4, a personal health record (PHR) in South Carolina for beneficiaries covered by fee-for-service Medicare.** The tool was developed by HealthTrio, and the pilot is being managed by QSSI. Palmetto GBA will help to populate beneficiaries' records with key information from hospital and provider medical claims once an individual registers and requests the data. Prescription drug information, however, will not automatically be entered into the PHR, according to CMS. But a beneficiary can choose to enter his or her prescription drug and over-the-counter medication information into the PHR. CMS said the PHR allows individuals to look up information specific to their own personal health status and health conditions and control who is able to see or share the information. Call CMS spokesperson Steve Hahn at (202) 690-6149.

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